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	295023	A. BUILDING _____ B. WING _____	08/22/2008

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CARSON CONVALESCENT CENTER	2898 HIGHWAY 50 EAST CARSON CITY, NV 89701

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of an annual Medicare recertification survey conducted at your facility on 8/19/08 through 8/22/08. The census at the time of the survey was 54. The sample size was 15. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and policy review it was determined that the facility staff failed to notify the physician that a resident refused insulin as ordered (#2), and that a residents pain medication was not providing adequate relief (#15).

Findings include:

Resident #2: The resident was admitted to the facility on 6/30/08, with diagnoses including uncontrolled insulin dependent diabetes, pneumonia, diabetic ketoacidosis, hypertension, and a decubitus ulcer.

Record review revealed that Resident #2 had refused to take the morning dose of long-acting insulin, as ordered, every morning for five days from 8/4/08 through 8/8/08. Record review revealed that a registered nurse contacted the physician to notify him of the resident's refusal of her morning insulin on 8/8/08 at 8:30 AM. No evidence was found inn the medical record that

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F 157	Continued From page 2 the physician had been notified before 8/8/08 at 8:30 AM. Review of the medical record also revealed that the resident required additional Novalog insulin/sliding scale coverage to treat an elevated blood sugar reading nine times during that same time period. The resident's blood sugar readings were as follows: 8/4/08 at bedtime - 231 8/5/08 at mealtime - 281; at bedtime - 242 8/6/08 before breakfast - 159; at bedtime - 291 8/7/08 before breakfast - 230; at bedtime - 251 8/8/08 at noon - 398 The Director of Nurses was interviewed on 8/22/08 at 8:15 AM, and reported that the refusal of insulin should have been reported to the physician promptly. Review of the facility policy and procedure entitled Medication Management Program (NP-M-28) dated 3/2006 revealed "If the patient/resident is unable to take the medication or refuses it, the authorized licensed/certified staff member circles his initials on the Medication Administration Record (MAR). (physician notified as necessary)" Cross reference F281 - Professional Standards of Practice Resident #15: The resident was admitted to the facility on 4/24/08, with diagnoses that included metastatic breast cancer, edema, diabetes, anxiety and delusional disorder. Her minimum data set (MDS) dated 7/22/08, revealed that her decision making ability was moderately impaired and her long and short term memories were impaired.	F 157		

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F 157	Continued From page 3 On 8/19/08, the licensed practical nurse revealed that Resident #15 had been complaining of pain and her pain drugs had not been providing adequate relief. She stated that she had to wait a few days for the resident's physician to return from vacation to obtain new pain medication orders for the resident. The nurse was asked if there were other physicians covering for the resident's physician. She stated that there were two physicians covering for the resident's attending physician, but she did not want to bother them. She had received an order from the attending physician to increase the resident's dosage of Methadone on 8/19/08 and the resident agreed to returning to the Hospice program. On 8/19/08, Resident #15 was interviewed and she reported she had received her medication and her pain had lessened. She stated that she had pain in her back, feet and legs. She reported that the pain could be very bad. The resident was alert but had difficulty recalling events prior to 8/19/08. Record review revealed that Resident #15 frequently complained of hip, leg, back and foot pain. On 7/28/08, her physician wrote that she had metastatic breast cancer and that "her left leg edema is almost certainly due to lymphedema secondary to cancer in pelvis." Cross reference F309 - Quality of Care	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164		

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F 164	Continued From page 4 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to protect the confidentiality of resident health information during telephone conversations and during the administration of medications for 2 of 15 residents (#6 and #15) and for random residents. Findings include: Resident #15: The resident was admitted to the facility on 4/24/08, with diagnoses that included	F 164		

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metastatic breast cancer, edema, diabetes, anxiety and delusional disorder.

On 8/20/08 at 9:50 AM, a licensed practical nurse (LPN) was observed on the telephone outside of the nurses station, discussing personal health information about Resident #15 in the presence of the surveyor, a certified nursing assistant (CNA), and another resident. The LPN was overheard reporting that Resident #15 had "cancer with metastasis to the bone, but I think a lot of the pain is in her head." She further reported that Resident #15 was currently taking Methadone and that the dose had been increased. She reported that the resident had taken all of the medication she could have until noon, and that after noon she could give the resident enough medication to cover her pain for the rest of the day.

The CNA was interviewed on 8/20/08 at 10:15 AM, and reported that nurse was speaking about Resident #15 because she had just reported to the nurse that the resident had requested pain medicine.

During the initial tour on 8/19/08 at 8:15 AM, the CNA had reported to the surveyor loudly about residents outside of their rooms including whether they were continent or incontinent and their ability to transfer. The residents had responded with "yes that's me."

The Director of Nurses (DON) was interviewed on 8/21/08 at 9:15 AM. The DON reported that the staff were to protect the residents' personal health information and that staff were educated about privacy and confidentiality. She further reported that speaking loudly about any resident's personal

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F 164	Continued From page 6 health information was not acceptable. On 8/20/08, the Medication Administration Record binder for the A wing was left open on the medication cart during a medication pass observation. The medication record contained the name of a resident, diagnoses and the medications she was taking. The sheet remained exposed for approximately five minutes. In addition, a nursing report sheet containing the residents' names and health related information was exposed during most of the medication pass. On 8/20/08, the Licensed Practical Nurse was informed of the opened medication administration record and nursing report sheet. She acknowledged that information on both forms was to be protected during the medication pass. On 8/21/08, the Director of Nurses was interviewed and confirmed that the medication record and the nurse's report sheet should have been protected to maintain the residents' privacy. A medication pass observation for B wing was conducted on 8/20/08. During the 30 minute observation a report sheet which contained resident names and health information was visible on the top of the medication cart. The registered nurse did not close the Medication Administration Record (MAR) for one of five med pass opportunities allowing visibility of a resident's medications and diagnoses.	F 164		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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This REQUIREMENT is not met as evidenced by:
Based on interview and observation, it was determined that the facility failed to ensure that residents received reasonable accommodations of their requested toileting needs and administration of medications for two random resident observations.

Findings include:

Random Resident #1: The resident was alert and oriented, but required wheelchair transport and a two person assist for transfer. The resident was interviewed on 8/20/08 at 1:30 PM. The interview revealed that the resident had experienced an episode of diarrhea during the lunch meal on 8/19/08. She had requested a certified nursing assistant (CNA) take her to the bathroom and the CNA told her that she would have to wait until the meal was finished. The resident stated that she was taken to the bathroom approximately 30 minutes later.

An interview was conducted with the CNA at 2:00 PM on 8/20/08. She confirmed that she was the CNA that had told the resident she would have to wait and that it was approximately 30 minutes before the resident was taken to the bathroom. The CNA stated that the resident was a two person assist and the CNA was by herself in the dining room. She acknowledged that she could have called for other staff to assist.

Interviews with two other CNA's on 8/20/08 and 8/21/08, an LPN on 8/20/08 and the Director of

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F 246	Continued From page 8 Nursing (DON) on 8/22/08, confirmed that residents requiring toileting during a meal should be taken out of the dining area at the time of their request. It was also confirmed that it was the responsibility of any nursing staff to assist with toileting, not just a CNA. Random Resident #2: The resident's spouse was observed at 8:00 AM on 8/20/08, to request that the licensed practical nurse (LPN) administer the the resident's morning medications as soon as possible so that the resident could leave the building. At 9:15 AM on 8/20/08, the resident and his spouse were still present in the facility. The spouse confirmed that the resident had not yet received his medications. An interview at 9:15 AM on 8/20/08, with the LPN revealed that the normal medication pass on that wing was at 9:00 AM. The LPN shared the medication cart with the nurse assigned to the other wing. The LPN was waiting until the other nurse signed off the medication cart, before administering medications on her wing. She confirmed that the resident's wife had requested his morning medications be given earlier so that the resident could leave the facility.	F 246		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to demonstrate	F 252		

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F 252	Continued From page 9 that they were actively controlling the presence of flies in the facility. Findings include: On 8/19/08 at 10:00 AM, flies were observed in the B wing dining room were residents were socializing. A resident was observed to swat at the flies with her hands. Two certified nurses aides (CNA) were in the dining room. When the CNA's were questioned about the flies they responded that it was a problem, but no action was taken to eliminate the flies. While talking with Resident #14 in her room on 8/19/08, flies were observed landing on the soiled shirt she was wearing; she kept swatting at them. She stated "they need to do something with the flies here. I have never seen them so bad." An interview with a nurse was conducted on 8/19/08 at 10:30 AM. She stated that a large fan was outside the entrance to the B wing dining area to help control the flies. When observed, the fan was turned off. The nurse turned it on and stated the fan was usually on to keep the flies from coming inside. There were no other preventative measures observed to control the flies. A conversation with a resident in the common area of B wing was conducted on 8/19/08 at approximately 10:00 AM. During the conversation two flies were observed near the resident and landed on her face and arms. The resident attempted to brush the flies away. Two employees approached the resident and one of the employees accompanied the resident back to the activity room.	F 252		

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F 252	Continued From page 10 The other employee confirmed that they saw the flies near the resident, but there was not anything that they could do. This employee stated that they were not allowed to use fly swatters. The Maintenance Director was interviewed on 8/19/08, after the interview with the resident. He confirmed that there was a pest light present in the dining room, but not anywhere else in the facility. He confirmed the flies were a problem. During this conversation, there were two to three flies in close proximity of the surveyor and staff. After this conversation it was observed that a CNA had a fly swatter and was attempting to eliminate the flies.	F 252		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that staff intervened and documented as necessary when medications were refused or not in the appropriate form for 2 of 15 residents. (#2 and #9) Findings include: Resident #2: The resident was admitted to the facility on 6/30/08, with diagnoses including uncontrolled insulin dependent diabetes, pneumonia, diabetic ketoacidosis, hypertension, and a decubitus ulcer. Record review revealed that the resident had	F 281		

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refused to take the morning dose of long-acting insulin, as ordered, every morning for five days from 8/4/08 through 8/8/08. Record review revealed that registered nurse (RN) #12 contacted the physician to notify him of the resident's refusal of her morning insulin on 8/8/08 at 8:30 AM. No evidence was found on the medical record that the physician had been notified before 8/8/08 at 8:30 AM. Review of the medical record also revealed that the resident required additional Novalog insulin/sliding scale coverage to treat elevated blood sugar readings nine times during that same time period.

The resident's blood sugar readings were as follows:
8/4/08 at bedtime - 231
8/5/08 at mealtime - 281; at bedtime - 242
8/6/08 before breakfast - 159; at bedtime - 291
8/7/08 before breakfast - 230; at bedtime - 251
8/8/08 at noon - 398

On 8/20/08 at 11:40 AM, Resident #2 was interviewed and reported that she had refused the medication because she had an episode of very low blood sugar that really frightened her, and she thought that it was related to the administration of the morning dose of the long acting insulin. She reported that it happened the "night before I started refusing the Lantus." She reported that she feared that "it (hypoglycemia) would happen again." When asked if the nursing staff had talked with her about her concerns she reported that no one had educated her about the need to comply with the physician's order, educated her about the way that the long-acting insulin works, or ways to prevent further episodes of hypoglycemia.

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Record review revealed no evidence of documentation that staff had educated Resident #2 about the need for compliance with her diabetes management.

The Director of Nurses was interviewed on 8/22/08 at 8:15 AM, and reported that the refusal of insulin should have been reported to the physician promptly. She further reported that the resident needed a lot of coaching to manage her diabetes because she had been making bad food choices. The DON reported that the resident had family members bringing in foods that were not appropriate for a diabetic. She reported that the nurses are expected to be educating her about all facets diabetes management including diet and the importance of compliance with her medication regimen.

Cross reference F157 - Notification
Resident #9: The resident was admitted to the facility on 5/2/06, with diagnoses that included end stage Alzheimer's disease, depression, and diabetes. The resident was receiving Hospice services.

During a medication administration observation on 8/20/08, the licensed practical nurse (LPN) stated that she was not going to give Resident #9 Docusate 100 mg (a stool softener) as ordered by her physician. She stated that she thought the resident was unable to swallow the capsule. She stated that she had not given the medication for the past two days (8/18/08 and 8/19/08) due to the resident's swallowing difficulty. She was then observed to crush and administer the resident's Senna tablet to her.

Review of the Medication Administration Record

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F 281	Continued From page 13 (MAR) revealed that the LPN wrote her initials on the record indicating the drug had been given on 8/18/08 and 8/19/08. She stated that she forgot to indicate that Docusate was not given on those days and proceeded to circle her initials which indicated the drug had been withheld. She stated that she had not sought to have the medication changed to a liquid or pill form or to another drug that the resident would be able to swallow. She stated she was not sure if the Hospice provided the Docusate in a form the resident could take. Review of Resident #9's record revealed that she did not have a bowel movement for the past three days, 8/17/08, 8/18/08, and 8/19/08. The resident received Morphine and Atropine which put her at risk for constipation. Review of the facility policy and procedure entitled Medication Management Program (NP-M-28) dated 3/06, revealed "If the patient/resident is unable to take the medication or refuses it, the authorized licensed/certified staff member circles his initials on the MAR. (physician notified as necessary)".	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 309		

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and review of facility policies and procedures, it was determined that the facility failed to follow their policies and procedures for pain management for 3 of 15 residents. (#12, #15, and #7)

Findings include:

Review of the facility's policy and procedure entitled "Pain Management" revealed "The facility recognizes that it has a commitment to provide patients/residents with a quick response to reports of pain, and will encourage patients/residents to participate in their pain management." The policy revealed that "Qualified staff will recognize that unrelieved pain has an enormous physiological and psychological effect on patients and residents, therefore, will effectively manage pain as a integral component of their care." In addition, the policy revealed that the patient/resident had a right to appropriate assessment and reassessment of pain.

Review of the facility's policy for medication administration and pain management revealed the nursing staff would assess each resident's pain using one of three pain scales available in the facility and document the findings on the "Pain Management Flow Sheet." These findings include date and time, pain rating, scale used, medication dose, alternative treatments, resident behaviors, vital signs, pain after intervention, comments, and the initials of who administered the medication.

Resident #12: The resident was admitted to the facility on 7/29/08, with diagnoses including cholecystitis, hypothyroidism, neuropathy, type II diabetes, congestive heart failure, and a

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F 309	Continued From page 15 depressive disorder. Record review for Resident #12 revealed an entry in the nurses notes dated 7/31/08 that read: "Daughter signed against medical advice (AMA) form, and calling ambulance to come take resident to" an acute care hospital. Resident #12's daughter was interviewed on 8/21/08 at 9:45 AM, and reported that her mother was very ill and the facility had not been "able to pick up on the signs" that she was very ill and needed to go to the hospital. She further reported that the resident had complained of terrific pain and was given Tylenol, but it did not relieve her pain. She stated that she had requested that the nurses give the resident "something stronger" because the Tylenol was ineffective, but the nurses would not respond. She reported that she requested that "the nurse have her mother sent to the hospital immediately because she was moaning and was full of fluid all over, and just swollen throughout her whole body," but the registered nurse (RN) kept telling her that there was no medical reason to send the resident to the hospital. The resident's daughter reported that the nurse had stated to her that she had called the physician to request an order to send the resident to the hospital, but that she would have to wait for him to return her call. The resident's daughter reported that she allowed ten minutes to pass for the doctor to return the call, but the call did not come after ten minutes, and she then called 911 herself. Review of the medical record revealed that Resident #12 was given Tylenol 650 milligrams on 7/31/08. No reference to time or reason for the administration of the medication was found.	F 309		

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Record review further revealed a "Pain Management Flowsheet" that was blank except for the resident's name, physician, record number, and room number.

On 8/22/08 at 2:00 PM, the RN was interviewed by telephone and reported that she had administered the Tylenol to Resident #12, but could not recall the time she had administered the medication, or whether or not the medication had been effective in relieving the resident's pain. She reported that she "vaguely remembered" that the resident reported that she had pain "all over."

Review of the resident's acute care facility record revealed that the Emergency Department physician made an entry on 7/31/08, reporting that Resident #12 had anasarca, "abdominal pain, and was painful all over" The report further stated that the resident had congestive heart failure that required treatment in the acute care setting.

Resident #15: The resident was admitted to the facility on 4/24/08, with diagnoses that included metastatic breast cancer, edema, diabetes, anxiety and delusional disorder. Her minimum data set (MDS) dated 7/22/08, revealed that her decision making ability was moderately impaired and her long and short term memories were impaired.

On 8/19/08, a licensed practical nurse (LPN) revealed that Resident #15 had been complaining of pain and her pain drugs had not been providing adequate relief. She stated that she had to wait a few days for the resident's physician to return from vacation to obtain new pain medication orders for the patient. The nurse was asked if

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there were other physicians covering for the resident's physician. She stated that there were two physicians covering for the resident's attending physician but did not want to bother them. She received an order from the attending physician upon his return on 8/19/08, to increase the resident's dosage of Methadone.

Record review revealed that Resident #15 frequently complained of hip, leg, back and foot pain. On 7/28/08, her physician wrote that she had metastatic breast cancer and that "her left leg edema is almost certainly due to lymphedema secondary to cancer in pelvis."

On 8/19/08, Resident #15 was interviewed and she reported she received her medication and her pain had lessened. She stated that she had pain in her back, legs, and feet. She reported that the pain could be very bad.

Review of the Pain Management Flow Sheet revealed that on 8/18/08, Resident #15 requested Oxycodone 10 mg three times. The Oxycodone order was for 10 mg every six hours as needed for moderate to severe pain. The resident's pain was assessed using the Wong-Baker Faces Pain Rating Scale and each time determined to be at a Level 4 which meant the resident indicated the pain "hurts a lot." The location of the resident's pain was not identified and the pain scale was not used following the medication administration to determine the degree of pain relief. The flowsheet revealed that the three doses of pain medication were described as "helpful" but did not use a scoring method or assessment to define "helpful."

Record review revealed that on 8/4/08 at 2:30

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PM, the LPN sent a fax to Resident #15's physician. The record revealed that the fax "let him know that resident has stated that her routine pain meds are not working that great anymore, also breakthrough Oxycodone is some help but doesn't last all that long." The physician was requested to increase the dosage of anyone of the pain medications ordered.

Record review revealed that on 8/5/08 at 9:15 AM, the physician faxed back with no new medication orders and asked that the nurse practitioner see Resident #15. The nurse practitioner saw the resident on 8/5/08. The resident's current order was for Oxycodone 5 mg every four hours. On 8/5/08, the nurse practitioner wrote an order for Oxycodone 10 mg every six hours for moderate to severe pain. The order was transcribed by the nurse on 8/5/08 at 9:10 AM. Over eighteen hours had elapsed between the resident's complaint of pain until the increase in pain medication.

On 8/22/08, the Director of Nurses (DON) and the Regional Administrator were interviewed. They both stated that the nurse should not have waited for Resident #15's physician to return from vacation to seek an adjustment in pain medication. The DON stated that a resident's pain should be dealt with promptly. She also stated that the nurse should have alerted her to the delay in obtaining a change in the resident's pain medication when the physician did not respond promptly to the nurse's faxed message. Attempts were made to contact the LPN regarding the faxed message to the resident's physician, but she could not be reached.

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F 309	Continued From page 19 Resident #7: The resident was admitted on 6/10/08, with the diagnoses of pilonidal cyst, tachycardia, diabetes, hypoxemia, back pain. Review of the Medication Administration Record (MAR) revealed that Resident #7 was given pain medication on 8/3/08, 8/5/08, 8/10/08, 8/11/08, 8/12/08, 8/16/08 and 8/17/08. The pain medication administrations were not recorded on the" Pain Management Flow Sheet." An interview with the DON and the regional administrator on 8/21/08 at 1:30 PM, confirmed that medication had been administered according to the documentation recorded on the Medication Administration Record (MAR), but was not documented on the facility's Pain Management Flow Sheet.	F 309		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to prepare and serve food under sanitary conditions by not controlling flies in the kitchen and not consistently labeling prepared food and beverages. Findings Include: Flies were observed in the tray line area during meal service on 8/20/08, and 8/21/08. The	F 371		

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Nutrition Director stated that she took precautions to prevent flies from entering the kitchen area, but they were still a problem. One fly was observed to land on the food prep area and another was on the steam table covers.

A full inspection of the kitchen was conducted on 8/21/08 at 9:00 AM in the presence of the Nutrition Director present. The large stationary mixer had dried food particles on the underside of the splash guard. The hand cranked can opener had a build up of moist debris on the blade and within the holder. The Nutrition Director stated that the can opener was to be cleaned daily. Wet nesting (the accumulation of fluid due to inadequate drying) was found between several pots and pans with clear liquid dripping approximately one tablespoon. Measuring cups stored in a drawer also had wet nesting with approximately one teaspoon of liquid between them.

Observation of the individual drinks prepared and stored on trays, revealed that some trays had dates and two trays did not. An interview with the Nutrition Director on 8/21/08 at 11:30 AM, revealed that some kitchen staff members date the drink trays on the date prepared and others did not. The Nutrition Director stated that each drink container was not dated individually and sometimes drinks can be moved from tray to tray which could lead to spoiled beverages being served. The Nutrition Director confirmed there was no consistency with how her staff label prepared drinks.
Observation of prepared food products revealed that the items were dated. An interview with the Nutrition Director and a cook on 8/19/08, revealed that items were dated when prepared and

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F 371	Continued From page 21 discarded 72 hours later. An item was observed to be dated 8/20/08. The Nutrition Director and cook confirmed that the item was prepared by a weekend cook, who labeled items with the date the item should be discarded. The Nutrition Director confirmed there was no consistency with how her staff label prepared items.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 22 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that medications were not accessible by unauthorized persons, failed to ensure that the use of all controlled substances was monitored in accordance with NAC 453.400, failed to ensure that residents did not receive outdated medications, and failed to ensure that drugs were stored at the proper temperature. Findings include: Review of the Nevada Administrative Code 453.400, Security of controlled substances, revealed that "all applicants and registrants shall establish and maintain effective controls and procedures to prevent or guard against theft and misuse of controlled substances." An observation of the facility's two medication rooms was conducted on 8/20/08. Located on the counters in each medication room was a portable plastic storage unit (similar to a tackle box) with multiple drawers and known by the facility as E-kits. The E-kits contained surplus medications including Schedule II, III and IV controlled medications as follows: Tylenol with Codeine #3, Duragesic (Fentanyl) patches, Hydrocodone, Morphine, OxyContin, Roxicet (Percocet), Valium, and Ativan. The E-kits had a numbered plastic "zip-lock" which was removed by cutting or twisting it. Replacement "zip-locks"	F 431		

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F 431	Continued From page 23 were located in the bottom drawer of each E-kit. The E-kits were not secured to the counter enabling removal from the medication room. Forms used to reorder medications were located next to the E-kits. The medications in the E-kits were listed in alphabetical order and the drawer where the medication was located was noted, but not how much of the drug was in the kit. The facility had no method to to accurately record the amount of controlled drugs or their removal from the E-kit. The facility had no record of when the E-kits were opened or any documentation of the zip-lock number that was removed or replaced. Interviews and observation with licensed nursing staff on both wings were conducted on 8/20/08. The staff confirmed that, at the change of each shift and when a nurse assumed accountability for the medication cart, the controlled drugs in the medication cart were counted. The staff interviews revealed that the facility had no method in place to count the narcotics that were in the E-kits. The staff stated the form listing all the drugs in the E-kits was used whenever a drug was removed from the E-kit. The form was sent to the pharmacy for replacement. The staff indicated that they did not know how many doses of the controlled drugs were supposed to be in the E-kits, because there was no sign-out sheet to ensure an accounting of the controlled substances. Nursing staff indicated that they were not present when the pharmacy technicians replaced the E-kit medications.	F 431		

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According to the Nevada Pharmacy Board controlled substances require double lock system; a "zip-lock" was not acceptable. A portable, plastic "tackle-box" that was not secured permanently to a location did not provide appropriate security. The Nevada Pharmacy Board confirmed that all controlled substances required an accurate checks and balance system which included the quantity of the drug that was present, documentation of date, time, amount and name/title of the licensed nursing staff when the drug was signed out. When a drug required disposal, such as a patient refusing it after it was removed, contamination of the medication or a partial dose waste, a co-signature of another licensed nursing staff member was required. This checks and balance system also required documentation when additional controlled substances were added, including co-signatures.

The E-kit in the A wing medication room contained the following expired medications: Amoxicillin (expired 6/08), Vitamin K (expired 7/1/08) SPS suspension (expired 5/08), Lonox (Atropine Sulfate) 2.5 mg. (expired 5/08), Risperdal (expired 5/08) and Ciprofloxacin 250 mg (expired 4/08).

Observation of the contents of the B wing E-kit revealed the following outdated medications: Risperdal (expired 5/08), Lonox (expired 5/08), Trimethobenzamide (expired 5/08), Diphenhydramine (expired 6/08), Kenalog (expired 4/08), Gentamycin (expired 4/08).

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An interview was conducted with the Director of Nursing (DON) on 8/20/08. The DON confirmed that the same process for all controlled substances should have been used as for those in the medication carts.

Interviews with the pharmacy manager and general manager of the pharmacy that managed the E-kits were conducted on 8/20/08. They confirmed that the pharmacy had no checks and balances regarding the controlled drugs in the E-kits, except for the form that the facility nursing staff completed. They also confirmed the facility did not sign for the receipt of controlled substances replaced in the E-kits. The pharmacy manager and general manager confirmed that the E-kits were to be checked every two months by the pharmacy technician for outdated drugs. Neither one could confirm when the boxes were last checked nor why drugs that had expired up to four months ago were in the E-kits.

An observation of the A wing medication room refrigerator revealed an undated, opened pneumonia vaccine multi-dose vial and an opened multi-dose tuberculosis test vial that was dated 6/10/08.

Observation of the B wing medication room refrigerator revealed five out-dated boxes of Flu vaccine (expired 6/08) and glucose solution test kits used to check the accuracy of the glucometer (expired 7/31/08). There were also open and undated vials of tuberculosis test solution and pneumococcal vaccine. The Flu vaccine boxes were located immediately under the freezer compartment of the refrigerator. Two of the Flu

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vaccine boxes were frozen to the underneath side of the freezer compartment and could not be removed during the inspection. The Flu vaccine storage recommendations were not to freeze the vaccine.

Observation of the A wing medication cart revealed one vial of Novolin R that was opened and undated. The B wing medication cart included three vials of insulin, Novolin R, Novolin 70/30 and Humulin N open and undated.

On 8/20/08 at 9:30 AM, the B wing medication cart was observed unlocked and unattended by a nurse for five minutes outside Room 34. One resident was observed near the medication cart.

Interviews with nursing staff on both A and B wings confirmed that night shift staff was responsible for checking out-dated medications, but also the responsibility of all staff to ensure proper labeling of medications and to check for out-dated drugs. The staff stated that this was not done on any regular basis, just whenever a nurse had time. It was acknowledged that the facility had no written documentation to demonstrate when expired medications were checked. Nursing staff on both wings confirmed that any multi-dose vials were to be dated when they were opened and discarded 30 days after opening.

On 8/20/08 at approximately 7:05 AM, a Licensed Practical Nurse (LPN) was observed preparing for the administration of medications. The medication cart was located approximately five feet from the door to the medication room on A wing. At 7:10 AM, the nurse left the cart to attend to a resident. She walked around the nurse's station and down the hallway, out of site of the

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	295023	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON CONVALESCENT CENTER	2898 HIGHWAY 50 EAST CARSON CITY, NV 89701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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medication cart. The medication cart was left unattended. The medication cart was unlocked and the drawers to the cart were easily opened exposing A wing residents medications. The medications were easily removed from the cart.

The LPN was told of the unlocked cart when she returned. She then pushed the medication cart up the A wing corridor to an area near the assisted dining room. She placed the cart against the wall with the medication drawers towards the wall. She proceeded to push a resident in a wheelchair down the hall past the B wing nurse's station and out of site of the medication cart. The cart was not locked and the medications drawers could be opened. The cart could be easily pulled away from the wall allowing access to the medications.

The LPN moved the cart to an area just outside the assisted dining room at approximately 7:20 AM. She entered the dining room to take resident vital signs. She was away from the cart for approximately ten minutes. The medication cart could not be observed from the dining room. The cart was unlocked and unattended. Resident medications could be removed from the cart.

On 8/20/08, at approximately 8:00 AM, the LPN moved the medication cart back to an area near the door of the medication room on A wing. She prepared Morphine and Lorazepam (controlled substances) in separate syringes for a resident. She left both medications on the top of the medication cart while she entered the medication room. The medication room door closed and the medication cart could not be seen by the nurse.

On 8/20/08, the LPN was interviewed regarding

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F 431	Continued From page 28 the unlocked medication cart. She acknowledged that the medication cart should be locked whenever unattended. The Director of Nurses (DON) was interviewed on 8/21/08 at approximately 2:00 PM and stated that the medication cart was required to be locked when it was not under supervision of a nurse and she acknowledged that medications cannot be left on the top of the medication cart unattended. Review of the facility policy and procedure entitled Medication Management Program (NP-M-28) dated 3/06, revealed that "the medication cart is kept in sight or locked at all times." The policy and procedure also revealed that "no medications or dangerous articles, i.e., gloves, lancets are left on top of the cart."	F 431		